

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the conditions of participation for ICFs/IID.

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

§ 442.119 Duration of denial of payments and subsequent termination of an ICF/IID.

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the conditions of participation for ICFs/IID; or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation for ICFs/IID during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in subpart D of part 431 of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

Subparts D–F [Reserved]

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

Sec.

447.1 Purpose.

447.10 Prohibition against reassignment of provider claims.

447.15 Acceptance of State payment as payment in full.

447.20 Provider restrictions: State plan requirements.

447.21 Reduction of payments to providers.

447.25 Direct payments to certain beneficiaries for physicians' or dentists' services.

447.26 Prohibition on payment for provider-preventable conditions.

447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.

447.31 Withholding Medicare payments to recover Medicaid overpayments.

447.40 Payments for reserving beds in institutions.

447.45 Timely claims payment.

447.46 Timely claims payment by MCOs.

MEDICAID PREMIUMS AND COST SHARING

447.50 Premiums and cost sharing: Basis and purpose.

447.51 Definitions.

447.52 Cost sharing.

447.53 Cost sharing for drugs.

447.54 Cost sharing for services furnished in a hospital emergency department.

447.55 Premiums.

447.56 Limitations on premiums and cost sharing.

447.57 Beneficiary and public notice requirements.1916A

447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

Subpart B—Payment Methods: General Provisions

447.200 Basis and purpose.

447.201 State plan requirements.

447.202 Audits.

447.203 Documentation of payment rates.